

1977

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## Recommended Citation

(1977) "Standard and Burden of Proof in Mental Commitment and Release Proceedings," *William Mitchell Law Review*: Vol. 3: Iss. 1, Article 6.

Available at: <http://open.mitchellhamline.edu/wmlr/vol3/iss1/6>

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## STANDARD AND BURDEN OF PROOF IN MENTAL COMMITMENT AND RELEASE PROCEEDINGS

### I. INTRODUCTION

Involuntary commitment<sup>1</sup> for mental disorders is a problem which affects a surprising number of Americans each year.<sup>2</sup> Historically, the procedural safeguards for the commitment process were either non-existent or grossly inadequate.<sup>3</sup> Recently, however, the Minnesota Legislature enacted reforms<sup>4</sup> which have improved the prospective patient's

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1. The Minnesota mental commitment statute provides for three methods of entry into a mental health facility: (1) informal hospitalization by consent, MINN. STAT. § 253A.03 (1976); (2) emergency hospitalization, *id.* § 253A.04; and (3) involuntary judicial commitment, *id.* § 253A.07. This Note will be concerned only with the release of persons under an involuntary judicial commitment, because under the informal or the emergency provisions release is granted within a specific time after request unless a petition for involuntary commitment is presented within that time. *See id.* § 253A.03(1) (person who consents to informal hospitalization "shall be free to leave the hospital within 12 hours of his request"); *id.* § 253A.04(3) (person admitted under the emergency hospitalization method may be held for up to 72 hours). Of course, a petition often is filed for involuntary commitment after the person is already hospitalized under either the informal or emergency admission.

2. In the year from June 30, 1975 to June 30, 1976, 243 persons were committed to Minnesota state mental health facilities as mentally ill, and an additional 12 as mentally ill and dangerous. Letter from Thyra Tyrrell, Office of Research and Statistics, Department of Public Welfare to William Mitchell Law Review (May 3, 1977). It has been estimated that one person in ten will have a significant mental illness in his lifetime. R. ROCK, *HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL* 1 (1968). This means that one out of every three families in this country will be affected by the hospitalization of one of their members under a mental commitment. *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 87th Cong., 1st Sess. 11* (1961) (statement of Alexander Wiley). The increasing magnitude of the problem and its growing legal implications are emphasized by the fact that the number of mental patients committed approximates, if not exceeds, the number of criminals sentenced and institutionalized in the same period of time. For example, in 1970, the number of inmates in correctional institutions in the United States was 328,020, whereas the number of persons in mental hospitals was 433,890. *See U.S. BUREAU OF THE CENSUS, DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES* 1974, at 45 (95th ed. 1974).

3. *See AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW* 5-7 (rev. ed. S. Brakel & R. Rock eds. 1971); R. ROCK, *supra* note 2, at 14. The earliest public concern with the confinement of the mentally ill was primarily for the protection of society. The commitment process in the eighteenth and early nineteenth centuries was extremely informal, consisting mainly of an interested party's request for the hospitalization of a person. In the colonial period, those considered dangerous were jailed and the others were treated as paupers. Only in the latter part of the nineteenth century was attention given to the protection of the patient's rights. *See id.* at 12. *See generally* AMERICAN BAR FOUNDATION, *supra* at 1-14.

4. Act of Apr. 11, 1974, ch. 482, 1974 Minn. Laws 1209 (codified in scattered sections of 253A, MINN. STAT.). *See generally* *Developments in Minnesota Law - Civil Commitment*, 59 MINN. L. REV. 791, 797-99 (1975).

constitutional safeguards at the commitment hearing, during confinement, and at the review proceedings. While these statutory reforms were definitely a positive development, they solved only a part of the problem, because the issues of the proper standard and burden of proof in the commitment and release processes<sup>5</sup> were left unresolved.

These remaining issues have not been discussed frequently by the courts or commentators, and what discussion does exist indicates conflicting opinions. These differences of opinion stem largely from the dual, civil-criminal nature of mental commitments. Although the proceedings are characterized as civil, a commitment is similar in many respects to a criminal conviction, especially if a person is committed as mentally ill and dangerous<sup>6</sup> and is not amenable to corrective treatment. Unlike the criminal, however, the civilly committed person may be confined involuntarily for an indefinite, potentially permanent term.<sup>7</sup> Consequently, procedural safeguards such as the proper standard and burden of proof are of crucial significance in ensuring that the person's

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5. Review and release procedures are the aspects of the mental commitment area most neglected by the legal and medical professions. Because of the indeterminate nature of the commitment, many of the existent problems of hospitalization are actually those of release. See R. Rock, *supra* note 2, at 261-62.

6. The state has two possible bases for the involuntary civil commitment of a person as mentally ill. The *parens patriae* power allows protection of persons who are incapable of protecting themselves, and the police power gives protection to society from individuals judged to endanger the public in some way.

The *parens patriae* rationale is the most frequently used basis for commitment. The assumption is that society has the duty to commit for treatment people who are sufficiently mentally disabled so as to be unable to decide on treatment for themselves. See Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 956-57 (1959). See generally *O'Connor v. Donaldson*, 422 U.S. 563, 580-85 (1975) (Burger, C. J., concurring); *Developments in the Law-Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1207-19 (1974) [hereinafter cited as *Developments*]. However, "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant." JOHN STUART MILL, *ON LIBERTY* 13 (C. Shields ed. 1956). See generally T. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY* 223-36 (1963).

The police power is often considered the most essential and least limited of governmental powers. See *District of Columbia v. Brooke*, 214 U.S. 138, 149 (1909) (dictum). There is no question but that the state can deprive a person of his liberty as punishment for various actions. The question is whether the mere potential of harmful behavior is sufficient justification. See Ross, *supra* at 955-56; *Developments, supra* at 1228-35.

7. The Minnesota statute provides for an initial commitment of no longer than 60 days during which the proposed patient is observed and receives treatment. After that time a judicial hearing must be held to determine the patient's current mental state. If the evidence of the medical record and the testimony presented at the hearing then indicate continued hospitalization is necessary, the patient may be indeterminately committed. See MINN. STAT. § 253A.07(17), (23), (25) (1976). Most state statutes have this type of provision rather than one allowing for specified determinate periods for recommitment. Therefore, most mental patients are committed indefinitely. See generally AMERICAN BAR FOUNDATION, *supra* note 3, at 49-59.

constitutional rights are not violated.<sup>8</sup>

The Minnesota Supreme Court recently discussed these issues in *In re Lausche*,<sup>9</sup> holding that the burden of proof at release proceedings is on the patient to establish by a preponderance of the evidence that his confinement should be ended. The court stated in dictum, however, that the burden at the original commitment is upon the party seeking commitment and the standard is the criminal one of beyond a reasonable doubt.<sup>10</sup>

This Note discusses Minnesota's treatment of the standard and burden of proof in commitment and release proceedings, analyzes developments in other jurisdictions, and suggests common law and statutory approaches for balancing the rights of the patient with the interest of the state in keeping mentally ill and dangerous persons confined.

## II. CURRENT PROCEDURE FOR COMMITMENT AND RELEASE IN MINNESOTA

Prior to an examination of the placement of the burden and standard of proof in mental commitment and release proceedings, an understanding of the mental commitment process is necessary.

Two categories of mentally ill persons exist in Minnesota.<sup>11</sup> A person may be found to be mentally ill or mentally ill *and* dangerous. A "mentally ill" person has been defined by the Minnesota Legislature as a person who has a psychiatric or other disorder which substantially impairs his mental health and who requires care and treatment.<sup>12</sup> A mentally ill person may be committed if his conduct indicates his self-control, judgment, and ability to handle his own affairs is lessened to the extent that hospitalization is necessary for his welfare or the protection of society.<sup>13</sup> Before a person can be committed as mentally ill and dangerous, an additional requirement must be satisfied; the person must be found dangerous to the public.<sup>14</sup> When making the decision to

8. See *In re Ballay*, 482 F.2d 648, 655 (D.C. Cir. 1973) (the nature of the interests involved when a person is involuntarily committed are within the fourteenth amendment due process clause); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds per curiam*, 414 U.S. 473 (1974).

9. 302 Minn. 65, 225 N.W.2d 366 (1974), *cert. denied*, 420 U.S. 993 (1975).

10. *In re Lausche*, 302 Minn. 65, 69, 225 N.W.2d 366, 369 (1974) (dictum), *cert. denied*, 420 U.S. 993 (1975).

11. This Note is concerned only with commitments and releases under MINN. STAT. ch. 253A (1976). Those persons committed as mentally deficient or inebriate are not included in the discussion.

12. See MINN. STAT. § 253A.02(3) (1976).

13. See *id.* § 253A.07(17)(a). The statute requires that evidence of the person's conduct clearly show (1) he has attempted to or threatened to take his own life or attempted to do serious physical harm to himself or others; or (2) he has failed to protect himself from exploitation from others; or (3) he has failed to care for his own needs for food, clothing, shelter, safety, or medical care. See *id.*

14. See *id.* § 253A.07(17)(c).

commit, the court must consider the specific acts of the patient and the alternatives to involuntary commitment,<sup>15</sup> and must state for the record

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The obvious problems involved in finding a person "dangerous to the public" are primarily the difficulties of defining and predicting "dangerousness." Dangerousness to others involves consideration of three basic factors: the definition of dangerous conduct; the likelihood that a person will behave in a dangerous way if not confined; and the amount and type of evidence necessary to determine the first two factors.

A definition of dangerous behavior is generally expected to include the commission of a violent overt act against another person in the prospective patient's recent past. *See generally* Goldstein & Katz, *Dangerousness and Mental Illness—Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 70 YALE L.J. 225, 230 (1960); *Developments, supra* note 6, at 1236-40.

The most oft-quoted statistics on the predictability of dangerous behavior are based on a study of 969 mentally ill and dangerous patients who were released after the decision in *Baxstrom v. Herold*, 383 U.S. 107 (1966). The 969 patients had been confined in maximum security mental hospitals because of a determination that they were mentally ill and too dangerous to be released or committed to civil hospitals. One year after they were released or transferred, 147 had been sent into the community and the 702 other patients presented no problems to the minimum security hospitals. After several years, 27% were living normal lives in the community, only two had been convicted of a felony, and only 3% were in either a correctional institution or a hospital for the criminally insane. *See* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 712 (1974). *See generally* Hunt & Wiley, *Operation Baxstrom After One Year*, 124 AM. J. PSYCH. 974, 976 (1968); Steadman & Keveles, *The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-70*, 129 AM. J. PSYCH. 309 (1972). Another study on the prediction of dangerousness in criminal offenders included thorough clinical studies of persons convicted of serious assaults. A team of psychiatrists attempted predictions of dangerousness prior to court action regarding the patients' release or confinement. The results showed an 8% recidivism rate for the group classified as not dangerous and released upon the recommendation of the psychiatrists, and a 34.7% recidivism rate for the group considered dangerous by the psychiatrists and released by the courts. *See* Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELIN. 371, 377-78, 389-90 (1972). *But see* Monahan, *Dangerous Offenders: A Critique of Kozol, et al.*, 19 CRIME & DELIN. 418 (1973) (letter to the editor) (takes issue with the thesis that dangerousness can be readily diagnosed and treated). Many psychiatrists themselves admit that their ability to predict future dangerousness is no more reliable than the layman's, and to date there seems to be no accurate scale or list of suspect characteristics upon which to base a prediction. *But see In re Alexander*, 336 F. Supp. 1305, 1307 (D.D.C. 1972) (psychiatrists lend expertise to statutory construction of "dangerousness" that will prevent arbitrary commitment). *See generally* Coccozza & Steadman, *Some Refinements in the Measurement and Prediction of Dangerous Behavior*, 131 AM. J. PSYCH. 1012, 1014 (1974); Megaree, *The Prediction of Violence with Psychological Tests*, 2 CURRENT TOPICS IN CLINICAL & COMMUNITY PSYCH. 97 (C. Spielberger ed. 1970); Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCHIVES GEN. PSYCH. 397 (1972). In studies made of California's determinate commitment statutes requiring overt acts of violence toward another person, it was found that the mandatory release of dangerous patients did not increase the community's risk. A. URMER, *A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1970)*, reprinted in F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, *THE MENTAL HEALTH PROCESS* 267 (2d ed. 1976).

15. *See* MINN. STAT. § 253A.07(17)(a) (1976). The reasonable alternative dispositions to be considered include, but are not limited to, dismissal of the petition, care as an out-patient, informal or voluntary hospitalization in a private or public facility, appointment

why those alternatives were rejected.<sup>16</sup>

A person committed as mentally ill may obtain his release by convincing the head of the hospital that he is no longer in need of institutional care and treatment.<sup>17</sup> The procedures by which a person committed as mentally ill and dangerous is released are very demanding. He must appear before a special review board which determines whether he is capable of making a satisfactory adjustment in society.<sup>18</sup> The Commissioner of Public Welfare will order the patient's release upon the special review board's recommendation,<sup>19</sup> and unless a petition is filed by an aggrieved party<sup>20</sup> the commitment is terminated. If a petition is filed, the final decision will be made by an appeal board consisting of three probate judges.<sup>21</sup>

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of a guardian, or release prior to commitment. *See id.* Thus, involuntary commitment is tolerated only as a last resort. *Cf. Welsch v. Likins*, 373 F. Supp. 487, 501-02 (D. Minn. 1974) (due process requires good faith attempt to place mentally retarded persons committed involuntarily in settings least restrictive of their liberties); *Shelton v. Tucker*, 364 U.S. 479, 488 (1960) (any deprivation of a citizen's rights must be obtained by the least restrictive alternatives). *But see State v. Sanchez*, 80 N.M. 438, 457 P.2d 370 (1969) (absent statutory duty to seek alternatives to complete institutionalization, no duty to consider less drastic alternatives). *See generally Lake v. Cameron*, 267 F. Supp. 155 (D.D.C. 1967) (burden on court with assistance of government to explore least restrictive alternatives to commitment); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1145-200 (1972); *Developments*, *supra* note 6, at 1245-53. Police power commitments are influenced by the doctrine of the least restrictive alternatives because court decisions suggest that confinement must be discarded when another means of achieving the state's goal would be effective and would also lessen the restrictions placed on the individual. *See Developments*, *supra* at 1249-50.

16. *See* MINN. STAT. § 253A.07(13) (1976).

17. *See id.* § 253A.15(1). The head of the hospital has sole discretion in deciding a mental patient's readiness for release unless the patient has been charged with or convicted of a criminal offense. *See id.* Of course, in any kind of commitment, release by habeas corpus remains an alternative. *See id.* § 253A.21(3). In Minnesota, the writ of habeas corpus is available only to test the legality of the original detention and is, therefore, theoretically of no use if the patient was committed properly but is now recovered and entitled to release under existing standards. *See State ex rel. Anderson v. United States Veterans Hosp.*, 268 Minn. 213, 128 N.W.2d 710 (1964) (scope of habeas corpus inquiry limited to determination of whether committing court acted without jurisdiction over subject matter or person, whether law pursuant to which proceedings were taken is unconstitutional and hence void, and whether detention violated constitutional rights). Some jurisdictions have now extended the remedy if no proper treatment is being accorded. *See, e.g., Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966) (right to treatment cognizable in habeas corpus), *commented on in* Note, 45 TEX. L. REV. 777 (1967); *Hiatt v. Soucek*, 240 Iowa 300, 36 N.W.2d 432 (1949), *discussed in* Ross, *Commitment of the Mentally Ill: Problem of Law and Policy*, 57 MICH. L. REV. 945, 977-78 (1959).

18. *See* MINN. STAT. § 253A.15(2)(a) (1976).

19. *See id.* § 253A.15(2)(a), (b).

20. *See id.* § 253A.15(2)(c). The statute permits either the patient or the county attorney of the county from which the patient was committed to appeal. *See id.*

21. *See id.* § 253A.15(2)(b). The final orders of this board will supersede the commis-

Although the statutes set forth the procedures for judicial commitment and release, they do not specify upon whom the burden should be placed at these proceedings or what standard of proof must be met. Therefore, both the holding and dictum in *Lausche* embody the law regarding the burden and standard of proof in the mental commitment process in Minnesota today.

### III. BURDEN OF PROOF

Although for purpose of analysis the burden and standard of proof will be discussed separately, in reality they must be considered together to assess their effect on the mental commitment and release processes. The interrelationship between the burden and standard of proof is extremely important because a shifting of the former can affect fundamentally the impact of the latter, and the two combined establish the protection provided the patient in the proceedings. The burden of proof, however, is especially crucial, because if it is placed on the patient, he may be committed or refused release merely because he cannot prove effectively that he is neither mentally ill nor dangerous.

#### A. *The Present Rule*

The placement of the burden of proof never has been at issue in original commitment proceedings, where it is placed upon the party advocating the commitment.<sup>22</sup> It has caused problems, however, in release proceedings. In *Lausche*, the Minnesota Supreme Court considered the issue of placement of the burden of proof in the release proceedings of a patient committed as mentally ill and dangerous. The special review board and the appeal panel both placed the burden of proof on the patient to show that he was capable of making an adequate adjustment in society.<sup>23</sup> The supreme court agreed.<sup>24</sup> The apparent justification for the court's holding is found in the analogous *In re Masters*<sup>25</sup> case, where the court held that the burden was on the petitioner to prove his mental capacity by a "fair preponderance of the evidence," stating that

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sioner's orders in all cases. See *id.* § 253A.15(2)(c).

22. Cf. *McEleney v. Donovan*, 119 Minn. 294, 138 N.W. 306 (1912) (burden of persuasion rests upon proponent to establish the claim). See generally MCCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE § 337 (2d ed. E. Cleary 1972) [hereinafter cited as MCCORMICK].

23. The chief judge of the appeal panel stated that "[t]he procedure isn't too well described in the statute. I assume that, of course, this is a trial or hearing de novo, and the burden would be on the ward to establish his entitlement to discharge under the statute." Brief for Appellant at 20, *In re Lausche*, 302 Minn. 65, 225 N.W.2d 366 (1974), cert. denied, 420 U.S. 993 (1975).

24. See *In re Lausche*, 302 Minn. 65, 70, 225 N.W.2d 366, 369 (1974), cert. denied, 420 U.S. 993 (1975).

25. 216 Minn. 553, 13 N.W.2d 487 (1944).

the law assumes that insanity once shown will continue to exist.<sup>26</sup> The *Masters* court indicated that the interests of both society and the patient could be balanced best by placing the burden on the patient and requiring him to meet the less formidable civil standard rather than the formerly used standard of "clear and convincing evidence."<sup>27</sup> In *Lausche*, the court provided additional justification for its treatment of the burden of proof, stressing that if the burden is not placed upon the patient seeking release, the state at each release proceeding would have the same burden of proof as at the original commitment hearings. In effect, the court reasoned that whenever a patient requests a release hearing, the state would be required to rejustify the patient's confinement with the same quantum of proof as at the original commitment—a burden the court considered wasteful and unnecessary.<sup>28</sup> The court's concern with administrative convenience, however, is not convincing, especially when applied to a proceeding where the patient's future liberty is jeopardized.<sup>29</sup> The following discussion suggests a more appropriate method for determining the proper treatment of the burden of proof at the release proceeding.

### B. A Preferred Approach

Because the patient requesting release from hospitalization is seeking a change in the status quo, most courts apparently have assumed that the burden of proof should be placed upon him and not upon the party resisting the release.<sup>30</sup> The *Masters* court used the presumption of con-

26. See *id.* at 562, 13 N.W.2d at 492 (restoration to capacity of a feeble-minded person).

27. See *id.*

28. See *In re Lausche*, 302 Minn. 65, 70, 225 N.W.2d 366, 369 (1974), *cert. denied*, 420 U.S. 993 (1975). The court stated that "[t]o apply the higher standard to these proceedings would establish a procedure in which every patient committed as mentally ill and dangerous would require a recommitment every few months at his insistence." See *id.* Presumably the court meant to refer to the burden rather than the standard, because the patient obviously did not want the higher *standard* of proof if the *burden* was placed upon him.

29. See *Jackson v. Bishop*, 404 F.2d 571, 580 (8th Cir. 1968) (Blackmun, J.) ("Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations . . ."). See also *Rozecki v. Gaughan*, 459 F.2d 6, 8 (1st Cir. 1972); *Inmates of Suffolk County Jail v. Eisenstadt*, 360 F. Supp. 676, 687 (D. Mass. 1973) (incarceration of unsentenced inmates), *aff'd*, 494 F.2d 1196 (1st Cir.), *cert. denied sub nom. Hall v. Inmates of Suffolk County Jail*, 419 U.S. 977 (1974); *Martarella v. Kelley*, 359 F. Supp. 478, 481 (S.D.N.Y. 1973) ("constitutional rights cannot be denied on account of inadequacy of government resources"); *Wyatt v. Stickney*, 344 F. Supp. 373, 377 (M.D. Ala. 1972) (lack of funds no excuse for inadequate treatment of mentally ill), *aff'd in part, rev'd in part on other grounds sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Brenneman v. Madigan*, 343 F. Supp. 128, 139 (N.D. Cal. 1972) (expediency of administration no justification); *Hamilton v. Love*, 328 F. Supp. 1182, 1194 (E.D. Ark. 1971).

30. See, e.g., *Dixon v. Jacobs*, 427 F.2d 589, 598 (D.C. Cir. 1970); *Overholser v. O'Beirne*, 302 F.2d 852, 854 (D.C. Cir. 1961) (Burger, C.J.); *Ragsdale v. Overholser*, 281



tinued mental illness as the primary reason for placing the burden of proof upon the patient.<sup>31</sup> A change in the status quo should not be the sole factor considered, however. Allocation of the burden of proof traditionally turns on various factors. The other factors that should be taken into account, in addition to placement of the burden on the party seeking change, are the judicial estimate of the probabilities, fairness, and policy considerations.<sup>32</sup>

### 1. Estimate of Probabilities

The first additional factor to be considered is the estimate of the probabilities that one result normally will occur rather than another. The weight of statistical data in mental commitment situations substantiates the view that at least during the early period of confinement, the vast majority of mental patients improve sufficiently to be released.<sup>33</sup> Consequently, the probability is that a committed person will improve, and the burden of proof should reflect that probability. In addition, one of the primary justifications for commitment is to provide treatment for the patient's mental condition;<sup>34</sup> the *Masters'* presump-

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F.2d 943, 947 (D.C. Cir. 1960) (Burger, C.J.); *People v. Couvion*, 33 Ill. 2d 408, 411, 211 N.E.2d 746, 749 (1965); *People ex rel. Pauling v. Misevic*, 32 Ill. 2d 11, 203 N.E.2d 393 (1964), *cert. denied*, 380 U.S. 963 (1965); *Zellmer v. Catlin*, 253 Iowa 1080, 1083, 114 N.W.2d 925, 926 (1962); *Rosario v. State*, 42 Misc. 2d 699, 702-03, 248 N.Y.S.2d 734, 737 (Ct. Cl. 1964). *But see* Comment, *Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633, 654-60 (1967). *See generally* Szasz, *Hospital Refusal to Release Mental Patient*, 9 CLEV.-MAR. L. REV. 220 (1960).

31. *See* note 26 *supra* and accompanying text.

32. *See* MCCORMICK, *supra* note 22, § 337, at 788-89.

33. *See* NATIONAL INSTITUTE OF MENTAL HEALTH, DEP'T OF HEALTH, EDUC. & WELFARE, STATISTICAL NOTE 74: LENGTH OF STAY OF ADMISSIONS TO STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES 1971, at 2 (1973).

Of the 407,640 persons admitted to state and county mental hospitals during 1971, 86.9% were released within the first six months of admission, 3% died within those six months, and 10% were kept for six months or more. The median length of stay was about 40 days. *See id.* at 2.

In Minnesota, in the year ending June 30, 1976, approximately 399 persons were admitted as mentally ill with 243 committed after admission. An additional 30 persons were admitted as mentally ill and dangerous, and 12 of those persons were committed. In the same year, a total of 405 persons were finally discharged from the hospital, 333 were provisionally discharged, and an additional 415 were finally discharged from a provisional discharge. Statistics on the average length of stay of a mental patient in a Minnesota state hospital were unavailable at date of publication. Letter from Thyra Tyrrell, Office of Research and Statistics, Department of Public Welfare to William Mitchell Law Review (May 3, 1977).

34. The right to treatment within the institution has been recognized where a patient has been committed for the purpose of that treatment. *See generally* Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742 (1969); Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Katz, *The Right to Treatment—An Enchant-*

tion of continued mental illness contradicts that fact. If the justification is valid, the presumption should be that the patient will recover, not that he will remain mentally ill.<sup>35</sup>

As a result of not considering the estimate of the probabilities factor, the *Masters* court's placement of the burden of proof on the patient forces him to prove the negative fact that he is no longer mentally ill.<sup>36</sup>

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*ing Legal Fiction?*, 36 U. CHI. L. REV. 755 (1969); *Symposium—The Right to Treatment*, 57 GEO. L.J. 673 (1969); *Developments*, *supra* note 6, at 1316-51; Note, *The Rights of the Mentally Ill During Incarceration: The Developing Law*, 25 U. FLA. L. REV. 494 (1973); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).

In 1973, Minnesota created a statutory right to treatment. See MINN. STAT. § 253A.17(9) (1976). This statute provides that every person hospitalized or receiving services shall be entitled to receive proper care and treatment aimed at making further hospitalization unnecessary. The statute also provides for an individualized written program plan for each patient to be reviewed at specified intervals. See *id.* A Minnesota case has also held that the only constitutional justification for an abridgment of procedural rights is that the purpose of commitment is treatment. See *Welsch v. Likins*, 373 F. Supp. 487, 496 (D. Minn. 1974). For examples of cases discussing a statutory or combined statutory and constitutional right to treatment, see *In re Curry*, 452 F.2d 1360 (D.C. Cir. 1971); *Covington v. Harris*, 419 F.2d 617, 625-26 (D.C. Cir. 1969); *Dobson v. Cameron*, 383 F.2d 519 (D.C. Cir. 1967) (*per curiam*); *Tribby v. Cameron*, 379 F.2d 104 (D.C. Cir. 1967); *Millard v. Cameron*, 373 F.2d 468, 472-73 (D.C. Cir. 1966); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 233 N.E.2d 908 (1968).

Perhaps the most comprehensive analysis of the subject so far was the opinion in *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974), *vacated and remanded*, 422 U.S. 563 (1975), which stated that a constitutional right to treatment was based on the following reasoning: (1) where the rationale for confinement is *parens patriae*, the patient is in need of treatment, and the due process clause requires that minimally adequate treatment must be provided so that the nature of the commitment bears a reasonable relation to its purpose under *Jackson v. Indiana*, 406 U.S. 715 (1972); and, (2) when the three central limitations on the government's power to detain—that detention must be in retribution for a specific offense, that it be limited to a fixed term, and that it be only after a proceeding which includes procedural safeguards—are absent, a *quid pro quo*, in this case, adequate treatment, must be provided by the government.

Although treatment is not the primary purpose for the confinement, it is often a factor in the decision. Therefore, the person so committed has a due process right to have that treatment provided. The reasoning used in the sexual psychopath right to treatment cases is similar to that used where a patient has been committed as mentally ill and dangerous. See, e.g., *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973) (petition for writ of habeas corpus brought by person confined under the Illinois Sexually Dangerous Persons Act), *cert. denied*, 96 S. Ct. 1419 (1976); *Davy v. Sullivan*, 354 F. Supp. 1320, 1330 (M.D. Ala. 1973) (three-judge court) (*per curiam*) (treatment under Alabama's sexual psychopath statute must conform to minimum constitutional requirements).

35. See *Developments*, *supra* note 6, at 1391.

36. A recent Minnesota case held it is not necessary for a mental patient to prove that no person will be endangered by her release. See *Warner v. State*, \_\_\_ Minn. \_\_\_, 244 N.W.2d 640 (1976). Although Mrs. Warner had been committed under MINN. STAT. § 631.19 (1974) (superseded by MINN. R. CRIM. P. 20) (acquitted of murder by reason of insanity) rather than under the civil commitment procedure, the implications of the

Such a requirement is troublesome and inequitable, especially for a mentally ill and dangerous patient, because even if he shows that he has committed no recent overt dangerous acts, the state can rationalize this by the fact that he has been confined and has had little opportunity to commit such acts. Any factual evidence the "dangerous" patient can present in his own behalf rarely is enough to meet the burden. When the placement of the burden on the patient is coupled with the statutory provisions for indefinite commitment,<sup>37</sup> the result is that the patient, even if he has recovered, can seldom prove he is no longer dangerous. Therefore, the *Masters'* rule is unfair, against the weight of available medical evidence, and contrary to the underlying purposes of commitment.

## 2. Policy and Fairness

The Minnesota Supreme Court has held that the allocation of the burden of proof should be based primarily upon considerations of policy and fairness.<sup>38</sup> These considerations also apply in commitment and release proceedings; the patient should not have the burden of proving he is no longer mentally ill or mentally ill and dangerous. The physical and mental control the hospital staff exercises over the patient<sup>39</sup> presents

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holding are applicable to a patient committed as mentally ill and dangerous. The *Warner* court found that the patient need only show that the possibility of a relapse is slight, and that there is no reason to believe that a reoccurrence will constitute a danger to herself or others. See \_\_\_\_ Minn. at \_\_\_\_, 244 N.W.2d at 643. Despite the existence of various state statutory standards governing release of mental patients, a 1968 study of hospital practices found that actual discharge depends primarily on the determination of whether the patient can "get along in the community." See R. Rock, *supra* note 2, at 215-16. MINN. STAT. § 253A.15(1) (1976) provides that the head of the hospital shall discharge a patient when he is no longer in need of institutional care and treatment. But a dangerous or psychopathic personality cannot be discharged unless the special review board advises the Commissioner of Public Welfare that the patient is capable of making an acceptable adjustment in society. See *id.* § 253A.15(2).

37. See note 7 *supra* and accompanying text.

38. See *Rustad v. Great N. Ry.*, 122 Minn. 453, 456, 142 N.W. 727, 728 (1913).

39. Besides the obvious control the hospital has over the physical person of the patient in its custody, the use of tranquilizers and other drugs can inhibit the person's ability to assist his counsel in preparing a defense. In addition, the state has control over both the possession and contents of most of the psychiatric and hospital reports used as evidence. Because the proceedings are civil in nature, it is usually held that the patient has no fifth amendment right against self-incrimination. See, e.g., *State ex rel. Hawks v. Lazaro*, \_\_\_\_ W. Va. \_\_\_\_, \_\_\_\_, 202 S.E.2d 109, 126 (1974). Therefore, the doctors can use his statements or his lack of cooperation as evidence against him. Compare *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470 (1958) with *People v. Bruckman*, 33 Ill.2d 150, 210 N.E.2d 537 (1965). But in *Lessard v. Schmidt*, 349 F. Supp. 1078, 1101-02 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds*, 414 U.S. 473 (1974) (*per curiam*), a three-judge federal district court considered the patient's right to remain silent in a psychiatric interview and held that the fifth amendment privilege was an element of due

perhaps the greatest problem when he is seeking his release. When making its recommendations, the special review board relies on the patient's hospital record<sup>40</sup> as evidence of his improvement and renewed ability to adjust to society. Normally, however, that record is not only physically more accessible to the hospital staff than to the patient or his counsel,<sup>41</sup> but the actual contents of the record are written by the staff. The review of a mental commitment is a unique situation in that the very persons providing the primary evidence on which the patient must rely are also often his adversaries in regard to the matter at issue.<sup>42</sup> This is not to

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process in civil commitment. *Contra, Developments, supra* note 6, at 1303-12 (concluding *Lessard* holding erroneous regarding self-incrimination).

40. See MINN. STAT. § 253A.16(4) (1976). This statute provides that "[t]he board may examine the records of all patients admitted and may examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement in a mental hospital."

41. The patient may have a difficult time getting information and evidence for his own case. See R. Rankin & W. Dallmayr, *Rights of Patients in Mental Hospitals*, 329, 334, reprinted in *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. (1961). His right to talk to or interview outsiders may be limited, and if the patient is indigent, access to counsel and independent psychiatric help is additionally difficult. See *id.* at 342-43. See also Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 995-98 (1959). Although MINN. STAT. § 253A.07(15) (1976) requires counsel to be appointed upon request and MINN. STAT. § 253A.05(1) (1976) establishes the right to consult privately with counsel, often as a practical matter very little time is actually spent in consultation with the patient.

The argument is sometimes put forth that the hospital should also be required to furnish the patient with medical assistance for the hearing. South Dakota allows a patient to request appointment of an independent doctor for consultation. See S.D. CODIFIED LAWS § 27A-9-17 (1976). See generally *In re Gannon*, 123 N.J. Super. 104, 301 A.2d 493 (Somerset County Ct. 1973) (due process includes right to an independent psychiatric examination); Perr, *Independent Examination of Patients Hospitalized Against Their Will*, 131 AM. J. PSYCH. 765 (1974) (case studies of nine hospitalizations where private attorney requested independent psychiatric review demonstrates that three were hospitalized unmeritoriously).

42. The hospital staff which is supposed to aid the patient will very often be the force which opposes him in his desire to gain release. See, e.g., *Sarzen v. Gaughan*, 489 F.2d 1076, 1086 (1st Cir. 1973) (psychiatrist who determines person should be committed becomes a prosecutor). Dr. T. Szasz vehemently argues against this inherent adversary nature of the commitment process and insists that the mental patient must have full due process rights. See Szasz, *Hospital's Refusal to Release Mental Patient*, 9 CLEV.-MAR. L. REV. 220 (1960). Dr. Szasz stated:

My judgment will be considered correct, however, if due process in psychiatric affairs requires, first, that psychiatrists not mislead patients to believe they will help them, when, in fact, they are the agents of another party; and, second, that in each case in which psychiatry is used as a social force against a person, he will have equal access to psychiatric authority to use on his own behalf.

T. SZASZ, *supra* note 6, at 190. But see Davidson, *Mental Hospitals and the Civil Liberties Dilemma*, 51 MENTAL HYGIENE 371 (1967). For a general discussion of the court's role versus that of the hospital, see Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897 (1975).

suggest that either the doctors on the hospital staff or those on the board consciously wish to keep patients confined unjustifiably. Nonetheless, psychiatrists trained in diagnosis tend to see symptoms of mental illness where none exist.<sup>43</sup> The evidence they place in the medical record also is questionable because uniform diagnosis of the mental condition and prediction of continued mental illness and dangerousness is almost impossible to achieve.<sup>44</sup> This lack of uniformity works against the patient at the review, because it is possible for a person to be committed upon the testimony of only one psychiatrist,<sup>45</sup> but seldom will a person be

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43. Dr. Szasz has stated:

As judges and juries must decide whether a person is guilty or innocent, so physicians must decide whether a person is sick or well. Unfortunately, the rules governing the medical game are less explicitly formulated than those determining criminality. Physicians are taught always to suspect illness. Thus, they usually follow the rule that once a person is suspected of being ill, he should be considered sick until proved healthy.

T. SZASZ, *supra* note 6, at 224. See generally B. ENNIS & L. SIEGEL, *THE RIGHTS OF MENTAL PATIENTS* 292 (1973) ("Psychiatrists find what they expect to find"); Temerlin, *Diagnostic Bias in Community Mental Health*, 6 COMMUNITY MENTAL HEALTH J. 110 (1970) (diagnosis of one psychiatrist has biasing effect on later diagnosis of another psychiatrist); Temerlin, *Suggestion Effects in Psychiatric Diagnosis*, 147 J. NERVOUS & MENTAL DISEASE 349 (1968) (physicians follow the rule "when in doubt, diagnose illness," reasoning it is less dangerous than diagnosing health when illness may be present).

44. Clinical psychiatric interviews tend to be generally unreliable because they often last only a few minutes, are geared to the specific symptoms of the suspected illness, and are often couched in psychiatric clichés. See Scheff, *The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State*, 11 SOC. PROB. 401 (1964) (examiners prejudge the cases, proceed on a presumption of illness, and limit questioning to the circumstances leading to hospitalization). The outcome and diagnosis may depend as much on outside factors as on the answers and behavior of the person being interviewed. The personality of the examiner is the most important of these outside influences. Nathan, Andberg, Behan, & Patch, *Thirty-Two Observers and One Patient: A Study of Diagnostic Reliability*, 25 J. CLINICAL PSYCH. 9 (1969). His attitude may provoke lack of cooperation or actual hostility in the person being examined. Sex, see P. CHESLER, *WOMEN & MADNESS* 32-57 (1972), race, see Katz, Cole, & Lowery, *Studies of the Diagnostic Process: The Influence of Symptom Perception, Past Experience, and Ethnic Background on Diagnostic Decisions*, 125 AM. J. PSYCH. 937, 945-46 (1969), and theoretical orientation may influence the examiner's diagnosis and recommendations. Even the time and place of examination itself will vary the results. See B. ENNIS & L. SIEGEL, *THE RIGHTS OF MENTAL PATIENTS* 292 (1973). For examples and discussion of general studies of the unreliability and lack of validity of psychiatric judgments, see Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 697, 701-08 (1974). See generally *Solesbee v. Balkcom*, 339 U.S. 9, 24-25 (1950) (Frankfurter, J., dissenting) (recognizing there are "treacherous uncertainties in the present state of psychiatric knowledge"); J. ZISKIN, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY*, 181-214 (2d ed. 1975); Ash, *The Reliability of Psychiatric Diagnoses*, 44 J. ABNORMAL & SOC. PSYCH. 272 (1949).

45. See MINN. STAT. § 253A.07(2) (1976) (court to "appoint two examiners at least one of whom shall be a licensed physician"). Technically, therefore, the examiner need not even be a psychiatrist to qualify under statutory standards. See generally *Special Project*,

released unless several psychiatrists agree that he is no longer mentally ill.

The injustice of placing the burden of proof on the committed patient is demonstrated further by the fact that, in general, the longer a person is confined as mentally ill, the less able he is to advocate forcefully his right to release.<sup>46</sup> Studies indicate that involuntary treatment is most effective during the first few months of hospitalization,<sup>47</sup> but that institutionalization for an extended period of time actually contributes to the patient's mental deterioration and increased passivity.<sup>48</sup> Many pa-

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*The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 60 n.195 (1971). In addition, under the provisions of MINN. STAT. § 253A.16(1) (1976), the board appointed to review the admission and retention of patients need include only one person qualified in the diagnosis of mental illness.

46. See *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds per curiam*, 414 U.S. 473 (1974). Even a short detention may have long-lasting effects on an individual's ability to function in the outside world because of acute traumatic and iatrogenic symptoms caused by the involuntary detention itself in the alien atmosphere of the hospital. A period of time as short as several days can cause the onset of this type of symptom and can be the beginning of a process of institutionalization which further hinders both the patient's preparation for his hearing and his ability to function in society if released. See *id.* at 1091 n.18. For an example of how conditions in an institution for the mentally retarded can cause forms of maladjusted behavior including aggression, autism, total withdrawal, and excessive dependency on others, see Excerpt from Plaintiffs' Post-Trial Memorandum in *New York State Association for Retarded Children v. Rockefeller*, reprinted in 2 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 750-51 (B. Ennis & P. Friedman eds. 1973) (even a normal person placed in such conditions will experience regression and loss of personal effectiveness).

47. See Caffey, Galbrecht, & Klett, *Brief Hospitalization and Aftercare in the Treatment of Schizophrenia*, 24 ARCHIVES GEN. PSYCH. 81 (1971) (short-term patients show at least as much sustained improvement as those hospitalized for a long term); Glick, Hargreaves, Raskin, & Kutner, *Short Versus Long Term Hospitalization: A Prospective Controlled Study II. Results for Schizophrenic Inpatients*, 132 AM. J. PSYCH. 385 (1975) (results after study of long-term versus short-term patients are inconclusive without study over a longer period, but seem to indicate better functioning of short-term patients); Herz, Endicott, & Spitzer, *Brief Hospitalization of Patients with Families: Initial Results*, 132 AM. J. PSYCH. 413, 413 (1975) (brief hospitalization is as good as standard hospitalization as regards symptoms and readmission rates, and is superior for role function). All three articles emphasize, however, that the studies may not necessarily mean that a short hospitalization is ideal for all patients.

48. See generally E. GOFFMAN, *ASYLUMS* 171-320 (1961). It has been stated that the effects of hospitalization can be so detrimental that if the patient is not released before two years have expired, he has a very good chance of dying within the hospital. See Bloomberg, *A Proposal for a Community-Based Hospital as a Branch of a State Hospital*, 116 AM. J. PSYCH. 814, 814 (1960). See also Mendel, *Brief Hospitalization Techniques*, 6 CURRENT PSYCH. THERAPIES 310, 315 (1966).

We must consider the following factors in each decision for hospitalization: (1) hospitalization may offer too much dependency gratification to the patient; (2) hospitalization may reinforce the patient's failure in life so much so that he will give up trying to live an extramural existence; (3) removal from contact with reality may be harmful; . . . and (5) the secondary effects of the hospitalization may be adverse.

tients lose even the desire to return to society after continued confinement,<sup>49</sup> and without this desire the ability to obtain their release is decreased significantly. Consequently, fairness and policy considerations require that the burden of proof at release proceedings be placed on the state to help ensure that patients capable of adjusting in society are released before the adverse effects of institutionalization impair both their ability and desire to return to society.

Various outside influences such as family<sup>50</sup> and community<sup>51</sup> pressures can also adversely affect the patient's chance of obtaining release. The desire to relieve the family of responsibility for the patient is often a major factor in the decision to continue his confinement.<sup>52</sup> In a study

*Id.* It seems reasonable to assume that the effects of the institutionalization would be magnified if the person had been diagnosed wrongly or was free of mental disorder at the initial commitment.

The mental condition of one whose mind is so deranged as to require imprisonment for his own and others' good is indeed pitiable. But the mental attitude of one who is falsely found insane and relegated to life imprisonment is beyond conception. No greater cruelty can be committed in the name of the law.

5 J. WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 1400, at 201 (J. Chadbourn rev. ed. 1974). See generally Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972).

49. See generally *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess. 267-68 (1969) (statement of Bruce J. Ennis); T. SZASZ, *supra* note 6, at 180; Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025, 1055 (1974).

50. The present Chief Justice, Warren Burger, in his dissent in *Kent v. United States*, 401 F.2d 408 (D.C. Cir. 1968) stated: "Lawmakers in recent years have been sensitive to the need to make civil commitment difficult recognizing the dangers of relatives 'farming' out their kindred into mental institutions for motives not always worthy." *Id.* at 416 n.4.

51. See note 77 *infra*. The public's aversion to contact even with the non-dangerous retarded person is illustrated by the difficulty in avoiding zoning prohibitions against group homes in residential areas. See, e.g., *Anderson v. City of Shoreview Res., Inc.*, No. 401575 (Minn. 2d Dist. Ct., filed June 24, 1975) (special use permit for mentally retarded homes held valid). Minnesota has recently enacted legislation removing this legal impediment, however. MINN. STAT. § 462.357(7) (1976) provides that for zoning purposes, a state-licensed group home for six or fewer mentally retarded individuals is to be considered a single family residence. See also CAL. WELF. & INST. CODE § 5116 (West Supp. 1976). Enforcement of the statutes has been legally difficult, however, and constitutional attacks have had limited success. See generally *Village of Belle Terre v. Boraas*, 416 U.S. 1 (1974). Lack of the patient's financial capability to exist in the general community may also be a deciding factor in the decision to retain him. See N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 95 (1971); Comment, *Commitment of the Mentally Ill—Superior Court of Los Angeles County*, 36 S. CAL. L. REV. 109, 115 (1962).

52. See Dix, *Hospitalization of the Mentally Ill in Wisconsin: A Need for a Reexamination*, 51 MARQ. L. REV. 1, 35-36 (1967); A. URMER, *A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1970)*, reprinted in F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, *THE MENTAL HEALTH PROCESS* 407 (2d ed. 1976); cf. R. ROCK, *supra* note 2, at 222 (the aged and infirm); Chambers, *Alternatives to Civil Commitment of the Mentally Ill*:

relating the length of hospitalization to various factors, the most important was found to be the desire of the family to have the patient released or, conversely, its desire for his continued confinement.<sup>53</sup> This attitude of the family seems to have even more influence with the psychiatrists than considerations of the patient's dangerousness or psychiatric symptoms.<sup>54</sup> In addition, the public's fear of the "dangerous" mental patient also can influence the decision of the psychiatrist regarding a recommendation to release.<sup>55</sup> Although available evidence establishes that the released mental patient normally is no more dangerous than any other citizen,<sup>56</sup> the public outcry that ensues after the rare occasions when a former mental patient does commit a dangerous act<sup>57</sup> is certain to have

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*Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1134 (1972) (many elderly and senile patients are committed to mental institutions simply because there is no one willing to care for them in outside society).

53. See Greenley, *The Psychiatric Patient's Family and Length of Hospitalization*, 13 J. HEALTH & SOC. BEHAVIOR 25 (1972).

54. See *id.* at 31.

55. See note 56 *infra*. The most cursory examination of mental release cases will disclose that fear of dangerous behavior is a most influential factor in the retention of the mental patient.

Once a petition for release is before the court, the central issue is the possible danger to the patient or the community that might result from release . . . . [M]ost judges expressed the opinion that they would order release only if convinced that to do so would not jeopardize the welfare of the patient or the community.

R. ROCK, *supra* note 2, at 239; see, e.g., *In re Lausche*, 302 Minn. 65, 69, 225 N.W.2d 366, 368 (1974), *cert. denied*, 420 U.S. 993 (1975). But see Greenley, *The Psychiatric Patient's Family and Length of Hospitalization*, 13 J. HEALTH & SOC. BEHAVIOR 25, 35 (1972) (only slight relationship between patient's potential dangerousness and family's desire for continued hospitalization).

56. See Pollak, *Is the Paroled Patient a Menace to the Community?*, 12 PSYCH. Q. 236, 238 (1938) (crime rate for the general public is fourteen times as high as that of paroled patients). See generally Cohen & Freeman, *How Dangerous to the Community are State Hospital Patients?*, CONN. STATE MED. J., Sept., 1945, at 697; Giovanni & Gurel, *Socially Disruptive Behavior of Ex-Mental Patients*, 17 ARCHIVES GEN. PSYCH. 146 (1967) (alcoholism or previous arrest rate more highly associated with post-hospital arrest than the fact of hospitalization *per se*); A. URMER, *A STUDY OF CALIFORNIA'S NEW MENTAL LAW* (1969-1970), reprinted in F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, *THE MENTAL HEALTH PROCESS* 265 (2d ed. 1976). The Giovanni study differed from all others in that all forms of criminal activity were taken into account, whether or not an arrest had been made. But see Rapoport & Lassen, *Dangerousness—Arrest Rate Comparisons of Discharged Patients and the General Population*, 121 AM. J. PSYCH. 776, 779 (1965) (former mental patients more frequently arrested for some types of crimes).

57. Cf., e.g., Minneapolis Tribune, Oct. 31, 1976, at 1B, col. 2. Recently, a \$30,000 fence was ordered built around the grounds of Anoka State Hospital. "The fence, nearly two-fifths of a mile around, was ordered in September by Gov. Wendell Anderson. It was the most visible response to date to what had been called 'a supercharged environment' in Anoka following the killing . . . by a patient who escaped . . ." See *id.* A major concern of the hospital was to "regain the confidence of the Anoka community." See *id.* Sept. 1, 1976, at 17A, col. 1.



a cautioning effect on the persons considering a patient's release.

The above factors—control of records and diagnosis, length of confinement, and family and community pressures—combine to make the committed person's barriers to release formidable. In a state such as Minnesota, where the term of commitment is indefinite, fairness and policy considerations strongly support placement of the burden of proof upon the party advocating continued confinement. As a matter of fairness, the patient already has numerous disadvantages in release proceedings, and as a matter of policy, the court should be especially protective of the patient's liberties when confinement is potentially unlimited.

#### IV. STANDARD OF PROOF

As was discussed, the removal of the burden of proof from a patient seeking his release is of limited use to him if the standard of proof is not similarly altered to correspond to that of the original commitment proceeding. The following discussion will analyze the appropriate standard to be used.

##### A. *At the Commitment*

The standard of proof utilized in an adjudicative proceeding represents the degree of error that should be tolerated in the fact-finding process. For example, in criminal cases the standard has long been the "beyond a reasonable doubt" test,<sup>58</sup> which recognizes that a person should not be deprived of his liberty without a high degree of certainty that the state has met its burden.<sup>59</sup> In contrast, the "preponderance of the evidence" test generally is used in civil cases where the interests at stake are normally economic in nature and there is less reason to tolerate an error in the defendant's favor than an error in the plaintiff's favor.<sup>60</sup> The standard of proof, therefore, is an important procedural safeguard that should be determined by balancing the interests at stake in the proceeding.<sup>61</sup>

The Minnesota Supreme Court in *Lausche* stated that the standard of proof at the original commitment is the criminal one of beyond a reasonable doubt.<sup>62</sup> Although dictum, this statement represents the first

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58. See, e.g., *In re Winship*, 397 U.S. 358, 362 (1970).

59. See generally *id.* at 361-64; McCORMICK, *supra* note 22, § 341.

60. See *In re Winship*, 397 U.S. 358, 371 (1970) (Harlan, J., concurring); *Developments*, *supra* note 6, at 1297. See generally McCORMICK, *supra* note 22, § 339.

61. See *In re Ballay*, 482 F.2d 648, 650, 653 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1086 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds*, 414 U.S. 473 (1974) (per curiam).

62. See *In re Lausche*, 302 Minn. 65, 69, 225 N.W.2d 366, 369 (1974) (dictum), *cert. denied*, 420 U.S. 993 (1975). In the past, the Minnesota court apparently has considered the "preponderance of the evidence" standard to be the appropriate one for all stages of

time the Minnesota court has addressed the standard of proof issue for commitment of persons as mentally ill and dangerous.<sup>63</sup> The court's conclusion is consistent with the recent handful of cases in other jurisdictions that have considered this issue.<sup>64</sup> These cases generally have analogized commitments to juvenile<sup>65</sup> and parole<sup>66</sup> proceedings and have

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the mental commitment process, primarily because of the civil nature of the proceedings. See, e.g., *In re Leary*, 272 Minn. 34, 136 N.W.2d 552 (1965); *In re Wretling*, 225 Minn. 554, 32 N.W.2d 161 (1948); *In re Masters*, 216 Minn. 553, 562, 13 N.W.2d 487, 492 (1944) (to obtain release must prove "present mental capacity by a fair preponderance of the evidence"; the proof need not be "clear and satisfactory").

63. *In re Masters*, 216 Minn. 553, 13 N.W.2d 487 (1944), the only other Minnesota case to address the standard of proof issue, involved instead a petition for restoration of capacity of a previously judged feeble-minded person under Act of Mar. 29, 1935, § 183, 1935 Minn. Laws 163 (repealed 1967) (formerly codified at MINN. STAT. § 525.78 (1941)).

64. See, e.g., *In re Ballay*, 482 F.2d 648, 669 (D.C. Cir. 1973); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1132 (D. Hawaii 1976); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1095 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds per curiam*, 414 U.S. 473 (1974); cf. *In re Winship*, 397 U.S. 358 (1970) (juvenile proceedings involving criminal charge); *United States ex rel. Stachulak v. Coughlin*, 520 F.2d 931, 935-37 (7th Cir. 1975) (three-judge court) (commitment under the Illinois Sexually Dangerous Persons Act), *cert. denied*, 96 S. Ct. 1419 (1976). Previously, the criminal standard had been applied with no particular analysis or discussion as to other possibilities. See, e.g., *In re Pickles*, 170 So. 2d 603, 614 (Fla. Dist. Ct. App. 1965); *In re Perry*, 137 N.J. Eq. 161, 43 A.2d 885 (Ch. 1945); cf. *Denton v. Commonwealth*, 383 S.W.2d 681, 682 (Ky. 1964) (commitment proceedings regarded as quasi-criminal). But see *Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide*, 49 N.Y.U.L. Rev. 227, 249-68 (1974) (use of the criminal standard would prevent all future commitments to prevent suicide because of the insufficient predictive accuracy). See generally *Bazelon, Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 748-49 (1969); *Developments, supra* note 6, at 1295-1303.

Proof by the standard of "clear and convincing" evidence has also been approved. See *Lynch v. Baxley*, 386 F. Supp. 378, 393 (M.D. Ala. 1974) (three-judge court); *People v. Sansone*, 18 Ill. App. 3d 315, 325-26, 309 N.E.2d 733, 740-41 (1974) (found the civil standard of proof by a preponderance inadequate and proof beyond a reasonable doubt not required by due process); *In re Valdez*, \_\_\_\_ N.M. \_\_\_\_, \_\_\_\_, 540 P.2d 818, 822-23 (1975) (beyond a reasonable doubt too stringent because psychiatry and psychology are inexact sciences); *In re Levias*, 83 Wash. 2d 253, 517 P.2d 588 (1973) (en banc); *State ex rel. Hawks v. Lazaro*, \_\_\_\_ W.Va. \_\_\_\_, \_\_\_\_, 202 S.E.2d 109, 126-27 (1974) (specifically disapproved of proof beyond a reasonable doubt standard because medical science inexact); cf. *Woodby v. Immigration & Nat. Serv.*, 385 U.S. 276 (1966) (deportation proceedings); *Bartley v. Kremens*, 402 F. Supp. 1039, 1051-53 (E.D. Pa.), *judgment stayed* 96 S.Ct. 558 (1975), *prob. juris. noted*, 96 S.Ct. 1457 (1976) (commitment of children). For a discussion regarding application of the various standards of commitment of sexual psychopaths, see *Comment, Commitment of Sexual Psychopaths and the Requirements of Procedural Due Process*, 44 FORDHAM L. REV. 923, 940-45 (1976).

65. See, e.g., *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973) (citing *In re Gault*, 387 U.S. 1 (1967) and *In re Winship*, 397 U.S. 358 (1970)); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (three-judge court) (same), *vacated and remanded on other grounds*, 414 U.S. 473 (1974) (*per curiam*). Because both juvenile and mental commitment proceedings are customarily characterized as *parens patriae* rather than adversary proceedings, the courts in the past have relied on the civil nature of the process to deny the concerned

concluded that due process in these proceedings requires the more stringent criminal standard of beyond a reasonable doubt to balance properly the interests of the state and the prospective patient.<sup>67</sup>

The degree of due process protection, and consequently the proper standard of proof, depends on the interests involved, the nature of the proceedings, and the purpose for which the proceedings exist.<sup>68</sup> In civil commitments, the state's interest and the purpose of the process depend upon the nature of the patient's alleged illness. If the patient is mentally ill, in need of treatment, and dangerous only to himself,<sup>69</sup> the state

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individuals' due process. The *Gault* court found the distinction unpersuasive and held that due process applies to juvenile adjudications. See 387 U.S. at 30-31. The mental commitment cases which apply the *Gault* rationale emphasize the similar restrictions on liberty and the future repercussions of a commitment that make the process similar to the juvenile process.

66. The court in *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973) based its deliberations on the analysis of *Morrissey v. Brewer*, 408 U.S. 471 (1972), a habeas corpus proceeding challenging the revocation of paroles without a hearing. The *Morrissey* court held that because of the interest of the parolee in his liberty, although conditional, and the interest of society in basic fairness, a hearing with due process protections was mandated. The *Ballay* court emphasized that the arguments for various due process standards are even more convincing in a mental commitment because the prospective patient stands to lose his "substantial liberty" as contrasted with the conditional liberty of the parolee. See 482 F.2d at 656.

67. See *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds per curiam*, 414 U.S. 473 (1974).

68. See, e.g., *Morrissey v. Brewer*, 408 U.S. 471 (1972); *Goldberg v. Kelly*, 397 U.S. 245 (1970); *Cafeteria & Restaurant Workers Union, Local 473 v. McElroy*, 367 U.S. 886, 894-95 (1961).

69. The Minnesota statutory criteria for "dangerousness to self" include finding the person mentally ill and

that the evidence of the proposed patient's conduct clearly shows that his customary self-control, judgment, and discretion in the conduct of his affairs and social relations is lessened to such an extent that hospitalization is necessary for his own welfare or the protection of society; that is, that the evidence of his conduct clearly shows: (i) that he has attempted to or threatened to take his own life or attempted to seriously physically harm himself or others; or (ii) that he has failed to protect himself from exploitation from others; or (iii) that he has failed to care for his own needs for food, clothing, shelter, or medical care.

See MINN. STAT. § 253A.07(17)(a) (1976).

Dangerousness to self is a classification that raises issues of vagueness and predictability in much the same way as dangerousness to others. Although protection of society from dangerously mentally ill persons necessitates use of the police power, arguably, a person's "right" to harm himself should be respected. See *Developments*, *supra* note 6, at 1223-28 (commitment for treatment should be restricted to the *parens patriae* actions, thus giving the state no control over a competent person's refusal to accept treatment). There is, furthermore, little evidence that suicidal tendencies are more predictable than dangerous acts toward others, or that hospitalization in any way influences the patient's behavior. See generally *Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide*, 49 N.Y.U.L. REV. 227 (1974); *Kiev, Prognostic Factors in Attempted Suicide*, 131 AM. J.

pursuant to its *parens patriae* power may commit him for the purpose of treatment.<sup>70</sup> A person mentally ill and dangerous only to himself may be hospitalized for an indefinite period, and the argument often is made that less stringent procedures can be tolerated because of the state's duty to help and care for him.<sup>71</sup> Pursuant to the *parens patriae* power, however, the state must provide treatment for the patient to justify the continued deprivation of his liberty.<sup>72</sup> In the case of a person allegedly mentally ill and dangerous to the public, rather than only to himself, the state cannot rely entirely on its *parens patriae* power to justify commitment, but must invoke its police power instead.<sup>73</sup> In most cases, the primary justification for committing a person mentally ill and dangerous to the public is the protection of society.<sup>74</sup> It is this interest which must be balanced against the committed person's substantial loss of liberty to determine the appropriate standard of proof.<sup>75</sup>

The state's police power interest in protecting society is the justification for both the commitment of mentally ill and dangerous persons and the incarceration of criminals. Similarities between the consequences of mental commitment and criminal conviction are obvious. In both, the person suffers a substantial loss of liberty<sup>76</sup> if the state's action is successful. In addition, both criminal and committed persons are later stigmatized by society as a result of their confinement.<sup>77</sup> These factors

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PSYCH. 987, 989 (1974); Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events*, 18 J. CONSULTING PSYCH. 397 (1954). A study of California's mandatory release statutes shows that the early release did not seem to change suicidal statistics. See A. URMER, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1970), reprinted in F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, THE MENTAL HEALTH PROCESS 289 (2d ed. 1976).

70. See notes 6 & 69 *supra*.

71. Cf. *Welsch v. Likins*, 373 F. Supp. 487, 496 (D. Minn. 1974). However, since *In re Winship*, 397 U.S. 358 (1970) and *In re Gault*, 387 U.S. 1 (1967), a therapeutic intention rather than a punitive one is irrelevant to the determination of procedural safeguards. The consequences of the proceedings, and not the purpose, mandate that criminal standards be used. See, e.g., *id.* at 36-37.

72. For a discussion of the right to treatment, see note 34 *supra*.

73. See note 6 *supra*.

74. See note 6 *supra*.

75. See *Developments*, *supra* note 6, at 1300-02. See generally Comment, *Commitment and Release Standards and Procedures: Uniform Treatment for the Mentally Ill*, 41 U. CHI. L. REV. 825 (1974).

76. See, e.g., *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (civil commitment entails a "massive curtailment of liberty" within the meaning of the fourteenth amendment). But see *People ex rel. Rogers v. Stanley*, 17 N.Y.2d 256, 260, 217 N.E.2d 636, 637, 270 N.Y.S.2d 573, 575 (1966) (Bergan, J., dissenting) (the situations in prisons and in mental hospitals are not analogous).

77. The former mental patient is often treated in a discriminatory manner, even if he was not declared incompetent. The general public will usually treat him with fear, mistrust, and dislike. He is often denied state and municipal civil service rank, is sometimes ineligible to drive a taxicab, may be denied admission to graduate and professional

and others indicate that the procedural safeguards provided civilly-committed persons should be at least as protective as those granted to criminals.<sup>78</sup> The protections offered in the criminal process are evident at every stage of the proceedings. For example, the criminal is tried in a system which offers highly developed procedural safeguards,<sup>79</sup> and he is usually incarcerated for only a specified period of time.<sup>80</sup> In addition, the criminal has the initial advantage of statutes which give him advance knowledge of the specific behavior that will bring about his trial and conviction. In contrast, in the commitment process persons are faced with the inherently vague terms "mentally ill"<sup>81</sup> and "dangerous."<sup>82</sup> Consequently, unless other factors merit a distinction, the criminal standard of beyond a reasonable doubt should be utilized in commitment proceedings.

The argument has been made that the state interest is sufficiently distinguishable in civil commitments of the mentally ill and dangerous to merit a different standard of proof than that provided for criminals.

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schools, and may have difficulty getting a public school teaching license. See B. ENNIS, PRISONERS OF PSYCHIATRY 143-76 (1972). One state has statutory protection for former patients against discrimination. See N.Y. MENTAL HYG. LAW § 15.01 (McKinney 1976) ("no person shall be deprived of any civil right, . . . solely by reason of receipt of services for a mental disability"). Cf. *Truax v. Raich*, 239 U.S. 33, 41 (1915) (the right to work is protected by the fourteenth amendment). See generally L. SROLE, T. LANGNER, S. MICHAEL, M. OPLER, & T. RENNIE, MENTAL ILLNESS IN THE METROPOLIS (1962); Reifler & Liptzin, *Entering College with a Psychiatric History*, 125 AM. J. PSYCH. 1625, 1629 (1969) (study showing former mental patients not a worse risk than other college students); *Developments*, *supra* note 6, at 1198-1201.

78. See *In re Ballay*, 482 F.2d 648, 662-67 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1090 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds per curiam*, 414 U.S. 473 (1974).

79. See e.g., *In re Winship*, 397 U.S. 358, 364 (1970) (proof beyond a reasonable doubt required in criminal proceedings); *Speiser v. Randall*, 357 U.S. 513, 520-26 (1958) (burden of proof on state); *Leland v. Oregon*, 343 U.S. 790, 795 (1952); *Holt v. United States*, 218 U.S. 245, 253 (1910) (Holmes, J.) (legal presumption of innocence); *Miles v. United States*, 103 U.S. 304, 312 (1880). "It is only because of historical accident that the procedural safeguards developed in criminal proceedings; there is nothing inherent in criminal proceedings that makes procedural safeguards relevant only there." L. PFEFFER, *THE LIBERTIES OF AN AMERICAN* 162 (2d ed. 1956).

80. See note 7 *supra* and accompanying text.

81. Commitment statutes are often constitutionally attacked as vague because they permit great discretion in labeling someone as mentally ill. See, e.g., *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270, 274 (1940) (not vague due to statutory construction); *Sas v. Maryland*, 334 F.2d 506, 514 (4th Cir. 1964) (remanded to consider vagueness); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds per curiam*, 414 U.S. 473 (1974) (not vague as interpreted); *Logan v. Arafteh*, 346 F. Supp. 1265, 1270-72 (D. Conn. 1972) (three-judge court), *aff'd mem. sub nom. Briggs v. Arafteh*, 411 U.S. 911 (1973) (court declined to consider vagueness); *State ex rel. Hawks v. Lazaro*, — W.Va. —, —, 202 S.E.2d 109, 123 (1974) (standard permitting involuntary hospitalization unconstitutionally vague).

82. See note 14 *supra*.

The state, some courts have asserted, also has an interest in the treatment of the patient,<sup>83</sup> and this additional state interest may justify a less stringent standard of proof than that used in criminal proceedings.<sup>84</sup> This reasoning, however, ignores the fact that confinement can and often does have a detrimental, negative effect on mental patients, particularly when the commitment was based on wrongful information.<sup>85</sup> In addition, the Minnesota Supreme Court has stated emphatically that a mentally ill and dangerous person may be committed even if he is not amenable to rehabilitative treatment.<sup>86</sup> Thus, treatment may not be required in Minnesota for commitment of a dangerous person.<sup>87</sup> There-

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83. In some cases, the patient may be considered virtually untreatable but the decision may still be made to confine him because of his potential social dangerousness. See *In re Lausche*, 302 Minn. 65, 69, 255 N.W.2d 366, 368 (1974), cert. denied, 420 U.S. 993 (1975) (mental patient who remains dangerous to public should not be released because there are no medical procedures that can change his possible character disorders or other symptoms); cf. *People v. Rancier*, 240 Cal. App. 2d 579, 585, 49 Cal. Rptr. 876, 881 (Dist. Ct. App. 1966) (untreatable sexual psychopath to be given compulsory treatment); *Barnes v. Director of Patuxent Inst.*, 240 Md. 32, 212 A.2d 465 (1965) (mentally defective delinquent). See generally *Developments in Minnesota Law—1974*, 59 MINN. L. REV. 785, 791-96 (1975). However, the assurance of treatment is a necessary justification even for persons who have committed criminal or anti-social actions. See *Tippett v. Maryland*, 436 F.2d 1153 (4th Cir. 1971) (statute committing mentally impaired criminals constitutional where adequate treatment assured); *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82 (1959) (civil commitment of sex offenders must provide adequate treatment to be constitutional).

84. See note 71 *supra*.

85. See notes 46 & 48 *supra*.

86. The *Lausche* court stated:

We would like to strongly emphasize to all those involved in the mental commitment procedure that the ward's actual release should not be predicated upon a prevailing opinion that treatment will not help, that hospitalization would be in vain, and that therefore the ward should be released. If the patient is judged mentally ill and dangerous, the rights of the public must be considered. Those who are a danger to the public are released at times because technically there are no medical procedures that can change their possible character disorders or other symptoms. The determining question should be: If not institutionalized, will they be a danger to society?

302 Minn. at 69, 225 N.W.2d at 368. The court also indicated that supervision alone might be sufficient treatment. See *id.*

87. The original right to treatment case, *Rouse v. Cameron*, 373 F.2d 451 (1966), suggested several constitutional attacks on confinement without treatment. The primary argument was that preventive detention for indefinite civil confinement without treatment constituted cruel and inhuman punishment. See *id.* at 453. The eighth amendment was interpreted in *Robinson v. California*, 370 U.S. 660, 666-67 (1962) (statute making narcotics addiction a crime and ordering punishment for it struck down on constitutional grounds). One reading of the *Robinson* dicta implies that all confinement for mental illness without treatment could be interpreted as cruel and unusual punishment, because the patients are not responsible for their condition. See *id.* at 666. One commentator has noted:

The *Robinson* dicta suggesting that civil commitment is constitutional are in

fore, the additional state interest in treatment of the patient does not justify the imposition of a less demanding standard of proof. Consequently, the *Lausche* dictum, that a person cannot be deprived of his liberty except by a finding that he is mentally ill and dangerous beyond a reasonable doubt, is sound and should be followed.

### B. At the Release Proceedings

The proper standard of proof at the release proceeding cannot be determined without first deciding which party bears the burden of proof. For example, in *Lausche*, the court held that the burden of proof at release proceedings is on the patient, but the standard of proof is the civil one of a preponderance of the evidence.<sup>88</sup> Assuming, as the court did, that the burden should be placed on the patient, the *Lausche* standard of proof benefits the patient. The preferred approach places the burden on the state at release proceedings to reestablish the patient's

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paragraphs expressing a favorable attitude to state action—even compulsory state action—assuring treatment for ill citizens. But commitment of dangerous persons is a harder case, because the chief purpose of such a measure is to afford protection for society, not to ensure treatment for the patient. If a case arose in which medical testimony indicated that a patient could not be helped by treatment (either because no treatment was known for his illness or because the available hospital had inadequate facilities), but he was nonetheless committed as dangerous, the Court might well hold that the state was punishing the patient for an illness and thus inflicting cruel and unusual punishment.

Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1291 (1966). *Contra*, *In re De La O*, 59 Cal. 2d 128, 378 P.2d 793, 28 Cal. Rptr. 489 (1963), cert. denied, 374 U.S. 856 (1963) (confinement via commitment proceedings is not per se cruel and unusual punishment). See generally Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations on the Decisions to Release Persons Acquitted By Reason of Insanity*, 70 YALE L.J. 225, 229 (1960) (purpose of civil commitment is to provide dangerous mental patients with state custody even if no treatment is available); *Developments*, supra note 6, at 1330-33; Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 97-100 (1967).

If continued confinement for "dangerousness" is permitted where a patient has not been determined currently mentally ill and treatable, obviously he is being detained for preventive reasons. Because other dangerous persons, such as incarcerated criminals, cannot be detained because they might be dangerous if released, permitting such preventive detention of the mental patient may fall within an equal protection argument. See Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1290 (1966). If a sociologist predicted that a person was 80% likely to commit a felony, no law would permit his confinement. Where a mental patient is declared 80% likely to commit a dangerous act, however, there is virtually no question but that he would be committed. It has been suggested that in the case of socially dangerous patients commitment should be for no longer than a prison sentence would have been for the "ancestor crime" which brought about the commitment. See generally *Due Process for All-Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633 (1967). For a discussion of the constitutionality of preventive detention, see Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).

88. See 302 Minn. at 70, 225 N.W.2d at 369.

mental illness and dangerousness beyond a reasonable doubt. This approach is more protective of the patient's liberty. The following discussion, therefore, is based on the premise that the burden is on the state at release proceedings.

The procedural safeguards are no less necessary at the release proceedings than at the original commitment.<sup>89</sup> At the original commitment, mental illness or dangerousness as to only that point in time is established.<sup>90</sup> Continued confinement, like the initial commitment, is justifiable only if the state's interest still substantially outweighs the patient's right to his liberty at the time of the release proceeding.<sup>91</sup> The United States Supreme Court has held that commitment cannot be continued beyond a period reasonably related to its original purpose;<sup>92</sup> it follows that a patient should be released when he no longer meets the criteria of the original commitment.<sup>93</sup> However, the Minnesota Supreme

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89. This area is often ignored in the commentaries. Constitutional safeguards benefit a patient little if he is denied adequate protections at the release stage.

90. See MINN. STAT. § 253A.15(1) (1976) (patient may be discharged when he is "no longer in need of institutional care and treatment") (emphasis added). See also NATIONAL INSTITUTE OF MENTAL HEALTH, FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL § 15 (Public Health Service Pub. No. 51, 1952), reprinted in AMERICAN BAR FOUNDATION, *supra* note 3, at 454-73.

91. See generally *Developments*, *supra* note 6, at 1389-92. For a discussion of standards of release, see note 93 *infra*.

92. In *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) the Supreme Court stated: "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." The Court held that the confinement due to lack of capacity to stand trial of a retarded person for three and a half years without treatment violated due process because the nature of his commitment bore no relationship to the treatment rationale of that commitment. See *id.* at 738. The Court also, and perhaps more significantly, stated that due process is violated if there is no reasonable relationship between the duration of confinement and its purpose. See *id.* Therefore, the custodial detention of patients after any realistic expectation of treatment has been exhausted would offend due process.

93. There is an inherent problem in the formulation of standards for release from a mental institution. The requirements for commitment are statutory and judicial. Release, however, is primarily a medical decision. Thus, a person may be considered in need of hospitalization by a court, yet be capable of discharge under medical standards. The converse is of more import, however, in the context of this Note. A patient may be ineligible for release in the opinion of the head of the hospital and not allowed a discharge pursuant to MINN. STAT. § 253A.15 (1976) even though he would not at that time meet the standards under which he was committed. This seems contrary to the policy behind the Draft Act which provides that the hospital administrator should order a patient's release when his present condition or actions would not justify an initial commitment. See NATIONAL INSTITUTE OF MENTAL HEALTH, FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL § 15 (Public Health Serv. Pub. No. 51, 1952), reprinted in AMERICAN BAR FOUNDATION, *supra* note 3, at 454-73. See generally Comment, *Commitment and Release Standards and Procedures: Uniform Treatment for the Mentally Ill*, 41 U. CHI. L. REV. 825 (1974); Comment, *Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633 (1967).



Court's holding regarding the standard and burden of proof at release proceedings makes possible the continued commitment of patients even if they are not sufficiently mentally ill or dangerous to justify an original commitment. The court accomplished this result by applying a different standard and burden of proof scheme for release proceedings than for the original commitment.

A Minnesota statute provides that a patient should be released when he is "capable of making an acceptable adjustment in society,"<sup>94</sup> which presumably means that the patient is no longer mentally ill<sup>95</sup> or dangerous.<sup>96</sup> The *Lausche* court held that the patient must establish his ability to adapt to society by a preponderance of the evidence.<sup>97</sup> The court's holding was based primarily on grounds of administrative convenience; the court was concerned that the state otherwise in effect would have to go through a new commitment process whenever the patient's status is reviewed.<sup>98</sup> This concern has some merit, because the administrative burden definitely would be increased by requiring the state to justify continued confinement by the beyond a reasonable doubt standard. Whether this inconvenience justifies lowering the patient's due process safeguards is questionable.<sup>99</sup> Because the patient's interest in his liberty remains the same, the only justification for relaxed procedural safeguards at the release proceedings is an additional state interest which did not exist at the original commitment.<sup>100</sup> The only such interest the

94. See MINN. STAT. § 253A.15(2) (1976).

95. Once the patient is hospitalized as mentally ill, however, a "label" such as "schizophrenic" (the most common) is attached to him, which will color every activity of his future life including discharge. Dr. Szasz maintains the label "frightens everyone, including the doctors." See T. SZASZ, *supra* note 6, at 175-76; notes 43 & 44 *supra*.

96. See notes 36 & 44 *supra* and accompanying text.

97. See *In re Lausche*, 302 Minn. 65, 70, 225 N.W.2d 366, 369 (1974), *cert. denied*, 420 U.S. 993 (1975).

98. See *id.* at 70, 225 N.W.2d at 369. The *Lausche* court advanced further reasons for not requiring the state to prove beyond a reasonable doubt that a mental patient should remain confined: (1) It implied that a dangerous patient might thereby be released into the public merely because he could not be treated; and, (2) it stated that the statutory provisions for release did not intend the review proceeding to be what would in effect be a recommitment. See *id.* at 69-70, 225 N.W.2d at 368-69.

99. See note 29 *supra*.

100. To justify a less protective burden and standard of proof at the release proceedings, the state must advance an additional strong interest that it did not have at the original commitment. If the initial commitment was for the purpose of treatment, and that treatment has not been given, presumably the state should give evidence of a new and more effective type of treatment that can be given in the future.

In *Baxstrom v. Herold*, 383 U.S. 107 (1966) and *Jackson v. Indiana*, 406 U.S. 715 (1972), the Court held that a prior conviction did not authorize less protective standards than those required for other civil commitments. By analogy it can be argued that prior confinement cannot be used as the necessary additional state interest to allow a lesser standard at the release proceeding.

*Lausche* court advanced is the increased administrative burden. Balanced against the patient's interest in his liberty, the administrative burden argument is not convincing, especially in light of the potentially indefinite commitment allowed by the Minnesota statute. Due process and fundamental fairness require that the standard and burden of proof at the release proceeding protect a person from confinement for a mental condition that would not have justified his original commitment. Therefore, the standard and burden of proof should be the same as at the original commitment.

### V. A STATUTORY APPROACH

The approach to the standard and burden of proof for release proceedings advocated in this Note is premised on the assumption that present Minnesota statutes will remain unchanged. Even if more protective safeguards are adopted by the Minnesota Supreme Court, the mental patient may still be protected inadequately because the present statutory scheme allows indefinite commitment. A more thorough remedy may be obtained by legislative action which provides for commitment for a specified period.<sup>101</sup> A good example is the recently-enacted California statute,<sup>102</sup> which mandates consecutive recertification periods of

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101. Several states have enacted determinate commitment statutes which mandate a recommitment process after a specified time, thus effectively removing the burden of proof from the patient. *See, e.g.*, Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5151, 5152, 5206, 5230, 5250, 5254, 5260, 5264, 5300, 5304 (West 1972 & Supp. 1976); FLA. STAT. ANN. § 394.467(3), (4) (West Supp. 1976) (new court order of retention required after first six months of confinement; right to notice, hearing, counsel, and independent psychiatrist; court can order retention for one year; once every year thereafter, new court order required); GA. CODE ANN. §§ 88-506.3, .6 (1971) (after first six months, new court order required every twelve months for retention of involuntary patient; hearing mandatory if requested within fifteen days of notice to extend hospitalization); ILL. ANN. STAT. ch. 91 1/2, § 10-2 (Smith-Hurd Supp. 1976) (judicial review once during first year and every two years thereafter; superintendent must justify retention of patient); ME. REV. STAT. tit. 34, § 2334(2) (Supp. 1976) (first commitment for four months; afterwards rehearing every year); MD. ANN. CODE art. 59, § 12 (1972) (automatic medical review annually; every involuntary patient must be recertified annually); N.H. REV. STAT. ANN. § 135-B:38 (Supp. 1975) (after two years order for commitment must be renewed by judicial hearing); N.Y. MENTAL HYG. LAW § 31.33 (McKinney 1976) (court-ordered commitments of six months, one year, then two year periods; patient must affirmatively demand a court hearing or commitment order solely on hospital's written application); N.C. GEN. STAT. §§ 122-58.8, .11 (Supp. 1975) (initial commitment for 90 days followed by automatic discharge or rehearing; second commitment not to exceed 180 days; afterwards annual review and rehearing); WASH. REV. CODE ANN. §§ 71.05.230, .240, .260, .280, .320 (1975 & Supp. 1976) (after initial 72-hour detention, court may order 14-day detention at probable cause hearing; additional 90-day confinement if patient threatened or attempted physical harm to himself or others or committed felonious acts while committed or "is gravely disabled"; then successive 180-day confinements if court ordered).

102. *See* Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5000-5404.1 (West 1972 & Supp. 1976), as amended by Act of Apr. 9, 1976, ch. 110, 1976 Cal. Legis. Serv.

fourteen days if additional treatment is required for an involuntarily committed patient.<sup>103</sup> Even a patient who has committed recent dangerous acts while in confinement must be recertified at the end of a ninety-day period or else be released.<sup>104</sup> Studies<sup>105</sup> made of the results of these mandatory release provisions indicate that the persons so released do not present any greater danger to themselves or others<sup>106</sup> and have as

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208 (West); Act of Sept. 12, 1976, ch. 905, 1976 Cal. Legis. Serv. 2316 (West); Act of Sept. 20, 1976, ch. 1109, 1976 Cal. Legis. Serv. 4680 (West).

103. See Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5254, 5264 (West 1972). The Act provides for a 72-hour evaluation confinement upon a written allegation of probable cause by a peace officer or "professional person." See *id.* § 5150 (West Supp. 1976). If the patient is then medically certified as dangerous or gravely disabled by mental disorder, and he will not accept voluntary treatment, he may be institutionalized for up to another 14 days for intensive treatment. See *id.* § 5250 (West 1972). The provisions for a suicidal patient are similar, except that if he has either attempted or threatened to take his own life during the time of hospitalization or has been committed for that reason and continues to present an imminent threat of so doing, he may be postcertified for a second 14 days. See *id.* § 5260. Both of these classes of patients must be released at the end of those time periods unless they qualify for additional treatment under other provisions of the statute. See, e.g., *id.* § 5300.

104. See *id.* §§ 5300, 5304 (West 1972 & Supp. 1976). The patient who is considered imminently dangerous to others can be postcertified for an additional 90 days after the initial 14-day period, but only if the state meets a very heavy burden of proof. It must be shown that the person has threatened or attempted to inflict physical harm on another person *after* having been taken into custody and continues to present an imminent threat of such harm or, in the alternative, that such an act was the precipitating factor in the original confinement, and as a result of a continuing mental disorder he continues to present such an imminent threat. See *id.* § 5300 (West 1972). This must be proved at a full judicial hearing within four days of the filing of the petition, and the patient may request a jury trial, in which case the verdict must be unanimous. See *id.* §§ 5302, 5303. At the end of the 90-day period, the patient must be released unless the procedure is again followed, in which case commitment can be for an additional 90 days only. See *id.* § 5304 (West Supp. 1976).

105. See, e.g., A. URMER, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1970), portions reprinted in F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, THE MENTAL HEALTH PROCESS 264-67, 289-90, 403-11 (2d ed. 1976). Criticisms that the *Lausche* court made and implied of a determinate recommitment procedure can be answered by examination of the results of the experimental Lanterman-Petris-Short Act, which looks to an eventual phaseout of involuntary commitments into state hospitals. Three major criticisms were made prior to enactment of that statute, and they correspond to the three classes of patients involuntarily committed: (1) those in need of treatment; (2) those dangerous to themselves; and (3) those dangerous to others. It was feared that because of the mandatory release patients would not receive an adequate amount of treatment, that suicidal patients would not be helped, and that dangerous patients would be released too early for the community's safety.

106. See A. URMER, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1970), reprinted in F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, THE MENTAL HEALTH PROCESS 265 (2d ed. 1976). Criticism of the Act before its passage was that a mandatory release would result in increased danger to the patients themselves, because suicidal patients would often have to be released against their doctor's advice. The results of the study impressively refute this contention. In a cohort group of 300 individuals used in the study,

good a prognosis for later adjustment<sup>107</sup> as do patients confined much longer under indeterminate commitment statutes. The California approach, and others like it, deserve serious consideration, and, if adopted in Minnesota, would go far to alleviate the existing procedural inadequacies of the mental commitment and release process.

## VI. CONCLUSION

A judicial change in the burden and standard of proof in the proceedings for release of a committed mental patient has been advocated in this Note. By imposing the burden of proving beyond a reasonable doubt that the patient is still mentally ill or mentally ill and dangerous on the petitioning party, the release proceeding would be changed, in effect, to a recommitment process. In addition, the proposed statutory change would mandate a series of recommitment proceedings at specific intervals in lieu of release proceedings. Whether this increased protection is provided to the committed patient by the legislature or by the courts is

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not a single one had committed suicide at the end of six months, a significant indication that early, required release of persons does not appear to influence suicide rates. An additional indication that a determinate scheme may even improve the suicidal patient's chances of recovery is the fact that the doctors chose to utilize the additional 14 days available for continued treatment in only one per cent of the cases studied.

The most innovative restrictions placed on the commitment process by the California statute concern the confinement of persons dangerous to others. The Act requires definite evidence of actual dangerous acts before a person can be postcertified for the additional 90-day period. This requirement was included to refute the common belief that mental patients are usually dangerous persons, and because of the lack of reliability of predictions of dangerous behavior and the lack of proof that treatment was any deterrent to that behavior. The study, along with court records for that period, disclosed that this much shorter period of confinement caused no increase in the occurrence of dangerous behavior and did not increase the risk to the community. This was the result even though most patients were not even recertified for the additional 90-day period and were only confined for the original 14 days.

107. See A. URMER, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1970), reprinted in F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, THE MENTAL HEALTH PROCESS 404 (2d ed. 1976). California's primary legislative change was placement of a limit on the length of time a person could be hospitalized for mental disorder. One of the major arguments against determinate commitment is that a patient cannot be adequately treated within the legal time and the confinement will, therefore, have a negative effect upon him. Although the *Lausche* court did not make this argument, it has been raised as a criticism of many protective release procedures. In a study made comparing various factors before and after the new statute, several pertinent findings were made. No significant difference was found in the psychiatrist's prognosis for the patient's recovery and adjustment between the patients released before and after enactment of the new statute; therefore, having the patient committed until the hospital considered him ready for discharge resulted in no better prognosis for his recovery. In addition, while the prognosis for voluntary patients did not change, it was significantly better for involuntary patients with the mandatory release provision. The implications of this result are that the longer periods of confinement and treatment are often not justified for an involuntary patient.

less important than the need that it somehow *be* provided. In this way we can prevent the imposition of possible life sentences, however benevolently intended, on both prospective mental patients and those already committed.